N.J.A.C. TITLE 8

CHAPTER 31A

AMBULATORY CARE FACILITY ASSESSMENT

Effective Dates: August 7, 2006
Expiration Date: August 7, 2011

Department of Health and Senior Services
Division of Health Facilities Evaluation and Licensing

AMBULATORY CARE FACILITY ASSESSMENT RULES

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SUBCHAPTER 1. GENERAL PROVISIONS

8:31A-1.1 Purpose and scope

(a) The purpose of this chapter is to implement the requirements of N.J.S.A. 26:2H-1 et seq.; specifically, N.J.S.A. 26:2H-18.57, amended by P.L. 2004, c. 54, which requires that the Department of Health and Senior Services assess a fee in the manner described in N.J.A.C. 8:31A-2 to each ambulatory care facility that is licensed to provide one or more of the ambulatory care services listed in (b) below.

(b) The provisions of this chapter shall apply to ambulatory care facilities that are licensed to provide one or more of the following ambulatory care services: ambulatory surgery, computerized axial tomography, comprehensive outpatient rehabilitation, extracorporeal shock wave lithotripsy, magnetic resonance imaging, megavoltage radiation oncology, positron emission tomography, orthotripsy and sleep disorder services.

(c) The provisions of this chapter shall not apply to an ambulatory care facility that is licensed to a hospital in this State as an off-site ambulatory care service facility.

8:31A-1.2 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the New Jersey Department of Health and Senior Services or his or her designee.

"Covered facility" means any ambulatory care facility that is required to be licensed by the Department to provide any of the following services: ambulatory surgery, computerized axial tomography, comprehensive outpatient rehabilitation, extracorporeal shock wave lithotripsy, magnetic resonance imaging, megavoltage radiation oncology, positron emission tomography, orthotripsy and sleep disorder services, unless the facility is licensed by the Department as a hospital-based off-site ambulatory care facility.

"De minimis amount" means a difference between the reported and audited gross receipts that results in less than a five percent understatement of the facility's assessment liability.

"Department" means the New Jersey Department of Health and Senior Services.

"Gross receipts" means the payments received by a covered facility for all health care services rendered in the facility. Gross receipts are net of returns and contractual allowances and other items that correct for payments that will not be received. However, gross receipts are not net of the costs of providing services, payments of taxes, or other costs.

"Uniform gross receipts assessment rate" means the rate that the Department uses to calculate the assessment on the gross revenues of covered facilities beginning with the SFY 2006 assessment. The Department calculated the rate according to N.J.S.A. 26:2H-18.57. The rate equals 2.9464494 percent.

SUBCHAPTER 2. ASSESSMENT

8:31A-2.1 Calculation of assessment

(a) For the State fiscal year 2005 (beginning July 1, 2004), each covered facility with at least $300,000 in gross receipts in calendar year 2003 shall remit to the Department an assessment of 3.5 percent of its gross receipts or $200,000, whichever amount is less.

(b) For the State fiscal year 2006 (beginning July 1, 2005), each covered facility with at least $300,000 in gross receipts in calendar year 2004 shall remit to the Department an assessment based on a uniform gross receipts assessment rate to be determined by the Commissioner using the 2004 data submitted to the Department by each covered facility as part of its annual reporting requirement under N.J.A.C. 8:31A-3 and calculated by the Commissioner so as to raise the same amount in the aggregate as was assessed in State fiscal year 2005, except that no covered facility shall pay an assessment greater than $200,000.

(c) Beginning in State fiscal year 2007, each covered facility with at least $300,000 in gross receipts, as documented in the facility's most recent annual report to the Department under N.J.A.C. 8:31A-3, shall remit to the Department an assessment based on the uniform gross receipts assessment rate determined by the Commissioner under (b) above, except that no facility shall pay an assessment greater than $200,000.

(d) The assessments under (a), (b) and (c) above shall be remitted to the Department in accordance with the timetable set forth at N.J.A.C. 8:31A-2.2.

8:31A-2.2 Payment of assessment

(a) Each covered facility shall pay annual assessments in four equal installment payments due on October 1, January 1, March 15, and June 15.

(b) In the event that a due date for submission of an installment payment falls on a weekend or a holiday, the payment shall be due on the first business day following the payment due date.

(c) Payments mailed shall be remitted to the following address: Financial Services, New Jersey Department of Health and Senior Services, 12D Quakerbridge Plaza, P.O. Box 360, Trenton, NJ 08625-0360. ATTN: Ambulatory Assessment.

(d) Payments hand delivered shall be remitted to the following address: Financial Services, New Jersey Department of Health and Senior Services, 12D Quakerbridge Plaza, Quakerbridge Road, Mercerville, NJ 08619; ATTN: Ambulatory Assessment; telephone (609) 584-4081.

8:31A-2.3 Appeal of assessment

(a) A covered facility may appeal an assessment issued by the Department under this subchapter.

(b) An appeal under this section shall be filed with the Commissioner, in writing, at the following address: Ambulatory Care Facility Assessment, Health Facilities Evaluation and Licensing, Department of Health and Senior Services, Assessment Appeal, P.O. Box 367, Trenton, New Jersey 08625-0367

(c) An appeal under this section shall list the factual and legal bases for the covered facility's challenge of the assessment, including citation to applicable provisions of the ambulatory care facility assessment rules, and shall include all written documentation supporting each appeal issue.

(d) An appeal under this section shall be filed by the covered facility within 30 calendar days of issuance of the notice of assessment by the Department.

(e) The appellant shall provide any additional information that is requested by the Commissioner.

(f) Failure by the appellant to adhere to the time limits or substantive requirements listed in (a) through (e) above may result in dismissal of the appeal.

(g) The Commissioner shall issue the final determination regarding all appeals under this section in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1, et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(h) A final determination by the Commissioner regarding an assessment appeal under this section shall not preclude the Department from subsequently performing an audit of the covered facility's annual report pertaining to that assessment under N.J.A.C. 8:31A-3.2, or from determining pursuant to such an audit that the covered facility had understated its gross receipts in its annual report to the Department for the fiscal year pertaining to the subject assessment or from retroactively increasing the covered facility's assessment for the subject fiscal year pursuant to the audit findings.

SUBCHAPTER 3. FINANCIAL REPORTING

8:31A-3.1 Annual report

(a) Each covered facility shall submit an annual report to the Department in hardcopy or on an electronic standardized Department form.

(b) The content and format of the annual report for covered facilities shall be available from Ambulatory Care Facility Assessment Program at P.O. Box 367, Trenton, New Jersey 08625-0367, telephone (609) 341-2124 and at http://nj.gov/health/hcsa/hcsaforms.html.

(c) The annual report shall be either certified or attested to by an accounting firm or by an officer of the covered facility.

(d) The annual report may include the charges, gross receipts and number of visits for which the covered facility provided reduced or no-fee care to patients based upon ability to pay and shall include the following:

1. Total volume of patient visits by payer type;
2. Charges by payer type; and
3. Gross receipts broken down by payer type into the following categories:

i. Medicare (fee-for-service and HMO);
ii. Medicaid (fee-for-service and HMO);
iii. Commercial (fee-for-service and HMO);;
iv. Other government payer; and
v. Self-pay.

(e) The timetable for submission of annual reports shall be as follows:

1. For State fiscal year 2005, all covered facilities shall provide proof of gross receipts for the calendar year 2003 to the Department no later than September 15, 2004. Covered facilities failing to provide proof of receipts by September 15, 2004, shall pay the maximum assessment of $200,000 for the State fiscal year.

2. For State fiscal year 2006 and thereafter, all covered facilities shall provide the annual report for the calendar year preceding the State fiscal year to the Department no later than May 31 preceding the start of the State fiscal year. Facilities failing to provide annual reports by June 30 preceding the start of the State fiscal year shall pay the maximum assessment of $200,000 for the State fiscal year.

(f) Annual reports mailed shall be submitted to the following address: Ambulatory Care Facility Assessment Program, Health Facilities Evaluation and Licensing, Department of Health and Senior Services, P.O. Box 367, Trenton, NJ 08625-0367; facsimile: (609) 633-9087.

(g) Annual reports hand delivered shall be submitted to the following address: Department of Health and Senior Services, 120 S. Stockton St, Lower Level, Trenton, NJ 08611; telephone (609) 341-2124.

8:31A-3.2 Audit of annual report

(a) The Department may audit selected covered facility annual reports to determine their accuracy.

(b) A staff member of each covered facility receiving an audit shall review the results of the audit with the auditor on-site and shall sign the audit where indicated to document receipt of the audit results.

(c) If, upon audit as provided for in this section, it is determined by the Department that a covered facility understated its gross receipts in its annual report by more than a de minimis amount, the covered facility's assessment for the fiscal year that was based on the defective report shall be retroactively increased by the Department to the appropriate amount and the facility shall be liable for a penalty in the amount set forth at N.J.A.C. 8:31A-4.1(c).

SUBCHAPTER 4. ENFORCEMENT

8:31A-4.1 Penalties

(a) A covered facility that fails to comply with N.J.A.C. 8:31A-3.1 shall be liable for a civil penalty not to exceed $500.00 for each day in which the covered facility is not in compliance.

(b) A covered facility that is operating one or more ambulatory care services listed in N.J.A.C. 8:31A-1.1(b) without a license from the Department, on or after July 1, 2004, shall be liable for double the amount of the assessment provided for in N.J.A.C. 8:31A-2.1, in addition to such other penalties as the Department may impose by law or rule for operating an ambulatory care facility without a license.

(c) If, upon audit as provided for in N.J.A.C. 8:31A-3.2, it is determined by the Department that a covered facility understated its gross receipts in its annual report by more than a de minimis amount, the covered facility shall be liable for a penalty in the amount of the difference between the original and corrected assessments.

8:31A-4.2 Procedures for enforcement and appeal

The procedural rules governing enforcement actions and appeals thereof under this subchapter may be found at N.J.A.C. 8:43E-3.2, Notice of violations and enforcement actions, 8:43E-3.3, Effective date of enforcement actions, and 8:43E-3.5, Failure to pay a penalty; remedies.